Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004419	A. BUILDING: _____ B. WING _____	05/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITLOCK HOUSE	1719 S ELM ST CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: May 1 and 2, 2013. Facility number: 004419 Provider number: 004419 AIM number: N/A Survey team: Laura Brashear, RN, TC Mary Weyls, RN Census bed type: Residential: 45 Total: 45 Census payor type: Other: 45 Total: 45 Sample: 8 Whitlock House was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality Review 05/06/13 by Lisa McColly.	R 000		